**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11040 (Rev. 06/03)

**WISCONSIN MEDICAID**

# PRIOR AUTHORIZATION / CHILD / ADOLESCENT DAY TREATMENT ATTACHMENT (PA/CADTA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Rd, Madison, WI 53784-0088.
**Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Child/Adolescent Day Treatment Attachment (CADTA) Completion Instructions (HCF 11040A).

❑ Initial /Request ❑ First Reauthorization ❑ Second Reauthorization ❑ Subsequent Reauthorization

## SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)
2. Age — Recipient
3. Recipient Medicaid Identification Number

## SECTION II — PROVIDER INFORMATION

4. Name — Day Treatment Provider
5. Day Treatment Provider's Medicaid Provider Number
6. Name — Contact Person
7. Telephone Number — Contact Person

## SECTION III — DOCUMENTATION

8. Indicate the requested start date and end date for this authorization period (if start date is prior to when request will be received by Wisconsin Medicaid, indicate rationale).

9. Indicate the number of hours of treatment to be provided over PA grant period. Indicate pattern of treatment, e.g., three hours per day, three days per week for eight weeks.

**SECTION III — DOCUMENTATION (Continued)**

The following additional information must be provided. If copies of existing records are attached to provide the information requested, **limit attachments to two pages for the psychiatric evaluation and illness / treatment history.** Highlighting relevant information is helpful. **Do not attach M-Team summaries, additional social service reports, court reports, or similar documents unless directed to do so following initial review of the documentation.**

10. Present a summary of the recipient's diagnostic assessment and differential diagnosis. **Diagnoses on all five axes of the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are required.** If not conducted by a psychiatrist or psychologist*, a psychiatrist or psychologist* must review and sign the summary and diagnoses.

*One who is listed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.

*Continued*

**SECTION III — DOCUMENTATION (Continued)**

11. Present a summary of the recipient's illness / treatment / medication history and other significant background information. Indicate why the provider thinks day treatment will produce positive change.

*Continued*

**SECTION III — DOCUMENTATION (Continued)**

12. Complete the checklist for determination that an individual meets the criteria for severe emotional disturbance (SED). Criteria for meeting the functional symptoms and impairments are found in the instructions. **The disability must be evidenced by a, b, c, and d listed below.**

a. **The individual must meet all three of the following:**

- ❑ Be under the age of 21.
- ❑ Have an emotional disability that has persisted for at least six months.
- ❑ That same disability must be expected to persist for a year or longer.

b. **A condition of SED** as defined by a mental or emotional disturbance listed in the most recent version of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*.

❑ _____

Primary Diagnosis

c. **Symptoms and functional impairments**

The individual must have one or two:

1. Symptoms (must have one)
   - ❑ Psychotic symptoms.
   - ❑ Suicidality.
   - ❑ Violence.

2. Functional impairments (must have two)
   - ❑ Functioning in self care.
   - ❑ Functioning in the community.
   - ❑ Functioning in social relationships.
   - ❑ Functioning in the family.
   - ❑ Functioning at school / work.

d. **The individual is receiving services from two or more of the following service systems.**

- ❑ Mental health.
- ❑ Social services.
- ❑ Child protective services.
- ❑ Juvenile justice.
- ❑ Special education.

Eligibility criteria waived under certain circumstances:

- ❑ This individual would otherwise meet the definition of SED, but has not yet received services from more than one system, but, in the judgement of the medical consultant, would be likely to do so were the intensity of treatment requested not provided. Attach explanation.
- ❑ This individual would otherwise meet the definition of SED, but functional impairment has not persisted for six months, or the judgement of the medical consultant, the nature of the acute episode is such that impairment in functioning (as defined in the "Severe Emotional Disturbance Criteria Checklist," January 29, 1992) is likely to be evident without the intensity of treatment requested. Attach explanation.

13. Describe the treatment program which will be provided. Attach a day treatment program schedule, if available. Summarize the proposed intervention in this section. The treatment plan should specify how program components relate to this specific client's treatment goals.

*Continued*

**SECTION III — DOCUMENTATION (Continued)**

14. Indicate the rationale for day treatment. Elaborate on this choice where prior outpatient (clinic) treatment is absent or limited. Why does the recipient need this level of intervention at this time?

15. Indicate the expected date for termination of day treatment. Describe anticipated service needs following completion of day treatment and transition plan.

**SECTION IV — ATTACHMENTS AND SIGNATURE**

16. Attach and **label** the following:

a. Documentation that the recipient had a comprehensive HealthCheck screen within the past year. A copy of this documentation must be attached for reauthorizations. (A copy of the original documentation may be used.) **The initial request for these services must be received by Wisconsin Medicaid within one year of when the HealthCheck screen was dated.**
b. A physician's prescription for day treatment services, signed by a physician, preferably a psychiatrist.
c. A day treatment services treatment plan. Either treatment plan must be signed by a psychiatrist or psychologist.*
d. A multi-agency treatment plan. The treatment plan must be signed by either a psychiatrist or psychologist.*
e. Results of either the Achenbach Child Behavior Checklist **or** the Child and Adolescent Functional Assessment Scale (CAFAS).
f. A Substance Abuse Assessment may be included. A Substance Abuse Assessment **must** be included if substance abuse-related programming is part of the recipient's treatment program.

I attest to the accuracy of the information on this PA request.

| 17. **SIGNATURE** — Day Treatment Program Director (Psychiatrist or Psychologist*) | 18. Date Signed |
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* One who is licensed in Wisconsin and listed, or eligible to be listed, in the national register of health care providers in psychology.

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